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ABSTRACT

This report summarizes what Scottish pupils between the ages of 8 and 17 years thought they needed from health education, and compares their views with those of parents, teachers, and health professionals. All groups agreed that healthy eating and personal hygiene were major priorities for the youngest pupils. Pupils and parents also mentioned the importance of drug education for this group, but only pupils included smoking as a priority. For older elementary pupils, all groups agreed that drug education, sex education, and smoking were priorities. Older primary pupils also included human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in their list of priorities. Drug education, HIV/AIDS, sex education, and alcohol education topped the list for more than half of the pupils in each secondary school age group. The survey also queried health professionals about local problem areas, queried parents about who should be responsible for health education, and examined whether pupils' needs for health education were being met. The survey found that, from the pupils' point of view, there was some doubt as to whether their priority topics were being aired in homes or schools. Health teachers are encouraged to monitor the impact of their programs and use the feedback as the starting point for a more focused approach. (JDD)

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THE SCOTTISH OFFICE
Education Department

INTERCHANGE

No 31

Health Education: What Do Young People Want To Know?

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Health Education: What Do Young People Want To Know?

Marion Devine

The Scottish Council for Research in Education

Introduction

Findings from an earlier survey by Devine and colleagues, commissioned by the Scottish Office Education Department, showed that the majority of teachers believed they were meeting the needs of young people in their health education programmes. What do young people themselves think?

This current research asked pupils between the ages of eight and 17 years what they thought they needed from health education. Interchange *summarises their views, and compares these with what parents, health professionals and teachers think pupils at different stages need to know.*

Teachers are responsible for planning health education which is appropriate to the ages of their pupils.

How often are young people themselves consulted about their health-related needs?

Study methods

Eight pairs of associated schools were chosen from across Scotland. Discussions were held with groups of pupils at P4, P7, S2, S4 and S6, as well as key members of staff responsible for health education, parent members of the school boards and health professionals connected with the schools. In each case the discussions were structured to allow a free exchange of what mattered in health education before going on to discuss selected topics. Questionnaires were also completed by classes of pupils at the same stages and parents of these pupils. In each secondary school, principal subject teachers were invited to respond to a questionnaire and the schools supplied us with the names and addresses of approximately 25 recent school leavers to contact for their views.

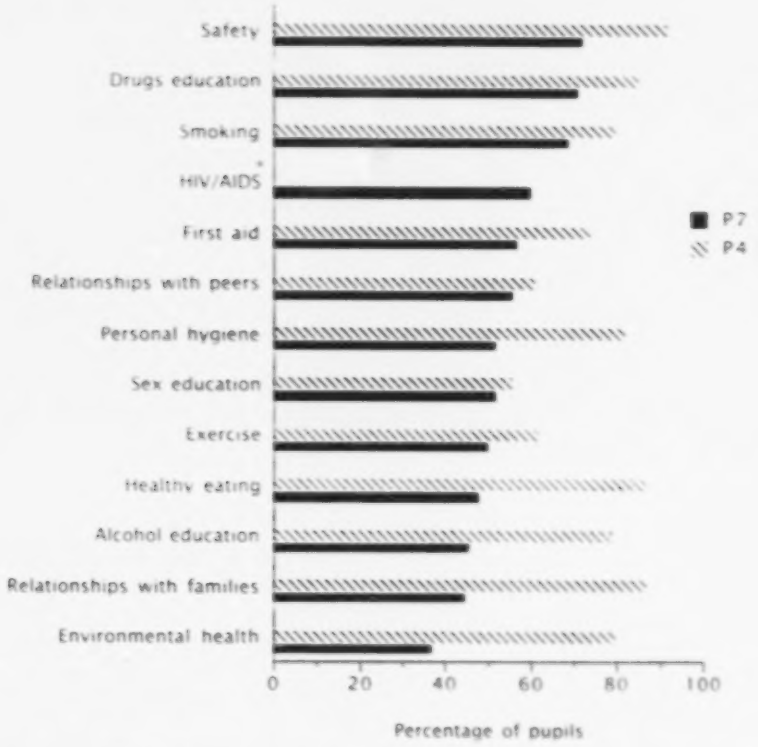
Primary school pupils

P4 and P7 pupils were given a list of topics and asked to say which were very important for people of their age to know about and to select three which were most important. For P7 pupils both questions resulted in very similar lists of priorities. This was not the case with younger pupils (Figure 1).

At P4, all 12 topics were thought to be very important by more than half of the pupils. Seven topics were very important to 80% or more pupils — safety, healthy eating, getting on with the family, drugs education, keeping yourself clean, looking after the environment and smoking. However, when the pupils selected the most important topics, these were healthy eating, personal hygiene, drugs education and smoking. At P7, fewer topics were chosen as 'very important' by the majority of pupils (nine out of the 13 listed) and the most important topics selected were drugs education, sex education, smoking and HIV/AIDS.

This limited list of most important topics had much in common with other groups. Pupils, teachers, parents and health professionals agreed that healthy eating and personal hygiene were major priorities for P4 pupils. Pupils and parents mentioned the importance of drugs education for P4 pupils, but only pupils included

Figure 1. Topics which were seen as 'very important' by pupils in P4 and P7



*HIV/AIDS was not included in the P4 question

smoking as a priority for their age group. Exercise was highlighted by teachers, parents and health professionals, with rest and sleep being specifically included under this heading by teachers and health professionals. Safety for P4s was a concern of parents and teachers, but aspects of safety raised by parents were limited to physical dangers such as roads, railways and canals or rivers rather than personal or emotional dangers.

For pupils at P7, parents, pupils, teachers and health professionals all agreed that drugs education, sex education and smoking were priorities. Again, health professionals were more specific by stressing puberty as the focus for sex education. Healthy eating for P7s was high on the agenda for parents, teachers and health professionals. Pupils at this age differed little from S2 pupils in their perceived needs; for example, including HIV/AIDS in their list of priorities. However, their parents took a different view of the inclusion of HIV/AIDS education for this age group.

Certain topics were mentioned as priorities by one or two groups only. For example, pupils at P4 mentioned smoking and pupils at P7 mentioned HIV/

Despite considerable agreement among the different groups, there were some differences in priorities for health education.

How are these differences in priorities to be reconciled?

AIDS. Whereas pupils and parents highlighted drugs education for P4, this was not seen as a priority for this age group by teachers or health professionals. Teachers were the only group who highlighted relationships as a topic for P4 and P7 pupils. In some cases these differences may be due to different interpretations of what is reasonable to include in health education. In other high profile areas, such as drug education and HIV/AIDS, it may be that media coverage influences what pupils are thought to need.

Secondary school pupils

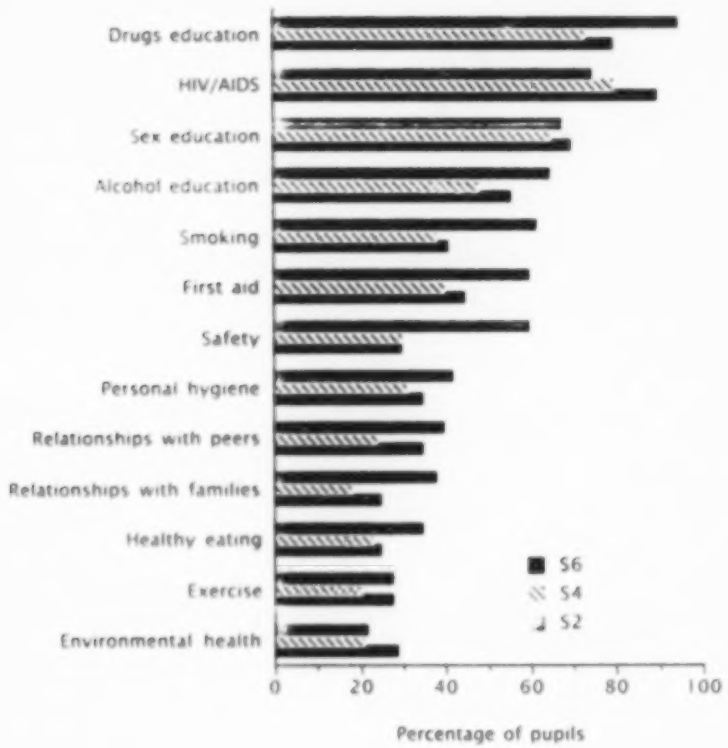
As with the younger pupils, S2, S4 and S6 pupils were given a list of health education topics and asked to indicate how important each topic was to people of their age group (Figure 2).

The same group of topics — drugs education, HIV/AIDS, sex education and alcohol education — topped the list for more than half of the pupils in each age group. A majority of S2 pupils also felt that smoking, safety and first aid were very important.

Pupils of different ages identified very similar areas as their major priorities.

How can teachers ensure that each topic is developed through from S2 to S6, without repetition, to take account of young people's increasing maturity?

Figure 2. Topics which were seen as 'very important' by pupils in S2, S4 and S6



Pupils' priority areas — the three aspects of health which were most important for young people of their age to know about — were compared with the priorities identified by parents, health professionals and teachers as appropriate for each age group. The most striking similarities were among the priorities of pupils and their parents; the same topics were chosen — drugs education, HIV/AIDS, sex education and alcohol education. All groups included smoking education as a priority for S2 pupils. Health professionals also stressed HIV/AIDS for both year groups and sex education for S4 but at S6 they were more specific in suggesting discussions on pregnancy and parenting skills. Both health professionals and teachers identified some aspect of emotional health as a priority for pupils at S2 and teachers included healthy eating and exercise for this age group.

Needs based on local problems

Health professionals were asked if there were any local problems which might make certain topics more important for schools in these areas. Among problems highlighted were local drug problems, particularly where there were parent users, and where signs relating to injected drugs were part of the everyday experience of the children. Alcohol was also cited where there was seen to be a local culture based on drinking. Poor diet related to a high level of coronary disease and poor dental hygiene were also mentioned in some areas. Most schools in these areas were already well aware of local problems and their health programmes reflected these concerns:

> *Children here know the evils of taking drugs. We're just trying to build up their personal skills to make decisions themselves and work out their responses to a situation before it happens. [P7 teacher]*

While some local problems are easily identified, others may not show themselves so readily.

How can teachers find out more about local health problems?

Who should be responsible for health education?

Most parents accepted that both the school and the home had a responsibility for discussing a wide range of health topics with the children. Even those parents who believed that they had the prime responsibility for certain areas recognised the need for the school to be involved:

> *School should provide a safety net. If the school were to miss topics some children would never discuss them. [secondary parent]*

Other parents took the view that there were certain areas where parents had insufficient knowledge to do justice to a topic and welcomed informed professional input.

> *I don't know the half of what they are talking about. How can I talk to them about drugs? [primary parent]*

From the list of topics in Figure 2, the majority of parents thought only one — 'Relationships within the family' — was most appropriately dealt with at home. However, during discussions with parent members of school boards, several parents mentioned advantages for family issues being aired in a general way in schools:

At home you are involved in the relationships so it's hard to step outside. To get a degree of objectivity it's probably better done through the school. They can discuss issues without getting emotional. *[primary parent]*

It is worrying for kids when they hear of other parents splitting up. You could do with education on how to cope with parents who have split up and how the children cope. *[secondary parent]*

More and more children are experiencing changes in the structure of the family.

What can teachers do to reassure parents that discussions about family relationships will not lead to a breach of their privacy?

Parents may be concerned that discussion in schools on relationships within the family could lead to children divulging private family problems. Teachers may have to make it clear to parents that such discussions would not be personalised and that issues would be tackled in general terms only.

Are pupils' needs for health education being met?

The study provides some evidence on the extent to which pupils' needs for health education are being met either at home or in school.

Priorities for younger pupils

P4 pupils identified healthy eating and personal hygiene as areas of priority and over three quarter of parents of primary children claimed that they often discussed these topics with their children. Almost 90% of the children themselves reported that these topics were discussed both in the home and at school.

P4 pupils also listed drugs education and smoking as important and here there appears to be a difference between what happens in the home and what happens in school. Only about one third of pupils said that these topics were discussed in school, although twice as many said they talked about them at home. This appears to reflect, in part, the priorities of the different groups of adults, as drugs education was seen as a priority for P4 pupils by parents but not by teachers or health professionals.

Priorities for older pupils

Because of the similarities between the views of pupils at P7 and S2, P7 pupils have been included with the older pupils. All groups of pupils included drug education, HIV/AIDS and sex education as major needs and Table 1 shows the percentage of pupils who said they discussed these topics at home, together with the percentage of parents who said that they discussed these topics with their children. Other topics such as smoking and alcohol which were priorities for certain groups only are included where relevant.

Although there were differences between the percentages of parents and pupils who reported discussions on each of the topics, the rank order was almost identical. The majority of pupils and parents said that the topics often discussed at home were drugs education, smoking and alcohol. Less

Table 1. Percentage of pupils and parents who often discussed these topics at home

	P7 pupils	*Primary parents*	*S2 pupils*	*S4 pupils*	*S6 pupils*	*Secondary parents*
Drugs education	45	57	43	36	38	64
HIV/AIDS	25	27	35	26	38	45
Sex education	36	30	40	32	32	46
Smoking	74	61	58	—	—	71
Alcohol education	—	—	43	50	52	67

than half agreed that HIV/AIDS and sex education were discussed by families at home. Bigger differences, such as 64% of parents compared with only 36–43% of pupils reporting that they discussed drugs education, could be explained in the words of one group of pupils interviewed:

It's not a discussion, you're told don't do it.

Given the agreed lack of discussion at home for the majority of pupils in a sensitive area such as sex education and HIV/AIDS, the school would seem to have a duty to ensure that all pupils have the opportunity to discuss and raise questions about sexual development and mores. However, it will be difficult to cater for the different wishes as expressed by parents:

I feel that sex education is being pushed at them at too early an age. If it's going to be done in school I'd be happier if it happened in secondary school. *[primary parent]*

Sex education needs to be earlier. It's quite easy when they are at that age [P7]. It gives them time to get through the puberty bit before they get to sex. *[secondary parent]*

Several parents from different schools welcomed the opportunity to watch videos used for sex education and, in at least one school, parent groups met to discuss sensitive issues:

They were having a parent group about AIDS and sex education. My girls are now ten and I wondered how I would approach the subject so I went down. *[primary parent]*

Some health professionals believed that there were advantages in giving the responsibility for sex education and related issues to medical experts:

... especially those who have been working in family planning who are up-to-date and have been educated to talk to pupils about sex education and contraception.

Some parents too were in favour of bringing in medical specialists. However, some parents felt this was better done by teachers:

I feel strongly that sex education, drugs, AIDS is done by educational people.

Several school nurses and doctors expressed their willingness to cooperate with teachers in planning appropriate lessons. This could be a useful

Parents had different opinions about whether and when to invite specialists from outside the school to talk to pupils about sensitive areas.

Is it better for specialists to talk directly to pupils or to train and support teachers to deal with sensitive areas themselves? What are the pros and cons of each approach?

compromise, particularly where the class teacher is unsure of how best to handle sensitive topics.

Table 2 show the percentage of pupils in different years who recalled lessons or discussions with teachers on the various topics.

Table 2. Percentage of pupils who often discussed these topics with teachers in school

	P7	*S2*	*S4*	*S6*
Drugs education	11	31	33	22
HIV/AIDS	10	25	57	46
Sex education	15	40	41	26
Smoking	36	47	—	—
Alcohol education	—	23	37	29

The low figure for HIV/AIDS at P7 is not surprising: HIV/AIDS was not seen by P7 teachers as a priority area and the researchers' discussions with these teachers suggest it is unlikely that this topic will be raised unless the children themselves do so. The other figures are more surprising and may be partly due to the deliberately opportunistic way in which primary teachers approach some of these issues; pupils therefore may not readily recall discussions which have been part of wide-ranging themes. Some primary teachers have also chosen, in collaboration with guidance staff in the secondary school, to postpone the discussion of drugs education and sex education until the children have entered the secondary school. However, given that all groups identified these areas as important for children in P7, some sharing of the responsibility between secondary and primary schools may have to be arranged.

In the secondary years the figures were higher, but S4 was the only group where a majority of pupils said that they had discussed one of their priorities. Some of the lower figures may partly be explained by the choice of year groups. Pupils were asked to respond with reference to their classes in the current year only and in at least one school the social education curriculum focused on health education in the 'between' years. However, the lower percentages at S6 could be a cause for concern as these are pupils who are about to leave school and many may also be about to leave home for the first time. As pupils mature their desire for privacy grows and must be respected. Teachers may feel that by the time pupils get to S6 they know all there is to know about, for example, sex education; yet a quotation from one of the senior pupils interviewed suggested that this is not so:

> *When you are younger, sex education isn't so relevant. It's just a laugh. It's not until you get into S5 and S6 that you start thinking about it and want to ask questions.*

The social education curriculum seems to be squeezed on all sides as it tries to take account of career guidance, records of achievement, study skills etc.

How can teachers use the results of this study to provide more focus for their health education programme?

Promoting good health

Deciding what to include in health education for children at different ages may be simplified by the apparent degree of consensus of what is important. For pupils from P7 onwards a common core of priority topics was identified by teachers, parents, health professionals and pupils themselves. However, teachers may want to be cautious about some of the topics identified by younger pupils, who may be influenced by issues in the forefront of the media. Topics such as drugs education at P4 and HIV/AIDS at P7 may have local relevance but not necessarily in all schools. Both local and national problems must continue to have their place in health education programmes. For example, healthy eating as part of the national challenge to improve the Scottish diet was recognised as a major topic by parents, teachers and health professionals for a wide age range of pupils.

Different groups interpreted health education in different ways.

To what extent do pupils and parents recognise that health refers not only to physical but also emotional and social wellbeing?

The majority of parents agreed that the school and the home were jointly responsible for most of the topics of health education. The need for schools to provide opportunities for open discussion is reinforced by parents, many of whom said that they did not discuss important topics at home. From the pupils' point of view, there was some doubt as to whether the topics they selected as priorities were being aired in schools either. It may be useful for teachers responsible for health education to monitor the impact of their own programmes with a sample of pupils and to use the feedback as the starting point for a more focused approach.

To some extent pupils, parents and health professionals had a narrower view of health education than teachers. The emotional aspects of health in terms of the importance of developing relationships were highly rated by teachers, particularly for primary school children, but not by pupils or parents and rarely by health professionals. Teachers may have to do more in the way of educating both parents and pupils about current thinking on the breadth of health education. In planning a health curriculum, teachers have to cater for both the current and future needs of pupils by constructing a programme that not only makes pupils aware of dangers to health but also suggests ways of promoting good health. By including emotional health teachers have further opportunities to accentuate the positive.

The next phase of the study will involve collaboration with teachers to improve the delivery of health education and promotion.

Further details of the study

This *Interchange* summarises work in progress. The study is due for completion in October 1995, after which the full report of the study will be made available. The report of the earlier study (see references) is available from SCRE, price £6.00.

The views expressed in this paper are those of the authors and do not necessarily reflect those of the Scottish Office Education Department who funded the study.

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Points for discussion

Consulting young people themselves

Reconciling the priorities of different groups

Developing topics over the stages

Finding out about local health problems

Ensuring privacy of the family in school discussions

Inviting specialists from outside schools

Providing focus for health education programmes

Encompassing emotional and social, as well as physical wellbeing

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